

Jaleh B. Farahmand, M.D.

Phone (703) 858-0055

Fax (703) 858-9575

GYN Medical History

Name _____ Date _____ Chart No. _____

I authorize this information is true & accurate: _____
Patient Signature

What has brought you here today?

Chief Complaint : _____

Menstrual History

1. What are the dates of your last 2 menstrual periods? 1. _____ 2. _____
2. How many days does your period normally last? _____ is flow: ___ Light ___ Moderate ___ Heavy
3. How many days between periods? (Count from start of period to start of next period) _____
4. Pain or cramps? ___Y ___N if yes, when in cycle, and what medications: _____
5. How old were you when you had your first period? _____

Obstetrical History

Number of Pregnancies ___ Full Term ___ Premature ___ Miscarriages ___ Abortions ___

Please list each pregnancy, including all information such as type delivery (vaginal or c-section), and include sex and condition of baby. Include miscarriages and abortions.

Date Place Type (vag, c-sec, etc) Anesthesia Labor Complications Wt. Baby

<u>Date</u>	<u>Place</u>	<u>Type (vag, c-sec, etc)</u>	<u>Anesthesia</u>	<u>Labor</u>	<u>Complications</u>	<u>Wt. Baby</u>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Past Medical History

Allergies to

anything/medicines/anesthetics/Latex: _____

If yes, what sort of reaction did you have? _____

Are you being treated for any illnesses or conditions by any other physician? ___Y ___N

If yes, explain: _____

Are you currently taking any medications, including birth control pills/hormones? ___Y ___N

If yes, please list: _____

Do you smoke cigarettes? ___Y ___N ... if yes, how many per day? _____

Do you drink alcohol? ___Y ___N ... if yes, how much per day? _____

Have you ever used illicit drugs? ___Y ___N... if yes, explain: _____

Ever had blood transfusion ___Y ___N ... if yes, when? _____

Please list all non-Obstetrical hospitalizations, surgeries, and outpatient surgeries.

Date Place Diagnosis describe Surgery or Medical Care M.D.

<u>Date</u>	<u>Place</u>	<u>Diagnosis</u>	<u>describe</u>	<u>Surgery or Medical Care</u>	<u>M.D.</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you ever had any of the following?

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
___	___	Hepatitis	___	___	Kidney or Bladder problems
___	___	Chickenpox	___	___	Thyroid Disease
___	___	Cancer	___	___	Blood Clots in legs or lungs
___	___	Migraines	___	___	Seizures
___	___	High Blood Pressure	___	___	Mental Problems or depression
___	___	Diabetes	___	___	Blood Diseases
___	___	Heart Disease	___	___	Endometriosis
___	___	Lung Disease	___	___	Bleeding Disorders
___	___	Sexually Transmitted Infections (if yes, list which _____)			

Abnormal PAP test ?

Do you perform monthly self-breast exam? _____
When was your last mammogram? _____ Result _____ PAP ----
Do you check your skin regularly for any abnormalities? _____
Have you had a tetanus shot in the last 10 years? _____
Are you considering pregnancy in the future? _____
If yes, have you had or been vaccinated against chicken pox? _____
And are you immune to German measles (Rubella)? _____
Have you had a cholesterol test in the last 5 years? _____ If yes, When _____ Result _____
Do you wear seat belts? _____
Do you exercise? _____ How often? _____

Family History

Has anyone in your family ever had any of the following?

Allergic Reactions to medications/anesthetics or reaction to anesthesia _____
Cancer (list relative and type of cancer) _____
Heart Disease before age 55 _____
High Blood Pressure or Stroke _____
Diabetes _____
Endometriosis, Uterine Fibroids _____
Bleeding Disorders _____
Any other medical problems _____

Review of Systems (Please circle if you currently have any of the following).

General Symptoms: Fever, sweats, fatigue, eating disorder, significant weight change.

Skin: Change in moles, new moles, skin lesions

Eyes: Change in vision, problem requiring visit to a physician.

Breasts: Lumps, pain, swelling, discharge, blood, trauma.

Respiratory System: Unexplained cough, coughing blood, wheezing, pain.

Cardiovascular System: Chest pain, short of breath (with exertion or not), palpitations, irregular.

Gastrointestinal System: Unexplained nausea, vomiting, vomit blood, constipation, diarrhea, pain, change in bowel habits, change in stool color (tarry, bloody), abdominal pain or jaundice.

Genitourinary System: Lose urine with cough/sneeze, urinate more frequently, bloody urine, pain.

Reproductive System: Abnormal bleed, pelvic pain, sexual dysfunction/pain, vaginal discharge, itching, burning

Musculoskeletal System: Joint pain, swelling, muscle, weakness, trauma, fracture.

Lymph Nodes: Enlargements or pain.

Nervous System: Numb or sensory change, paralysis, weakness, new headache, feeling depressed or mood problems